



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HARRIS METHODIST FT WORTH  
3255 W PIONEER PKWY  
ARLINGTON, TX 76013

#### **DWC Claim #:**

**Injured Employee:**

**Date of Injury:**

**Employer Name:**

**Insurance Carrier #:**

#### **Respondent Name**

CITY OF DALLAS

#### **Carrier's Austin Representative Box**

53

#### **MFDR Tracking Number**

M4-06-4923-02

#### **MFDR Date Received**

April 03, 2006

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary Dated December 21, 2005:** "This claim has been reimbursed; however, it was not processed according to the Acute Care Hospital Fee Guidelines set forth by the TWCC. Please review this information and reprocess this claim. Explanation: Stop Loss is an independent methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services. This methodology shall be used in place of and not in addition to the per diem based reimbursement system. Per TWCC guidelines, charges greater than \$40,000 are to be paid at 75% of billed charges. **In the case of carve-outs identified by revenue codes, the whole bill is paid according to the stop-loss provision if the threshold is reached. Therefore, there will be no overlap between carve-outs identified by pharmacy carve outs and carve outs identified by revenue codes and stop-loss, allowing analysis of each factor. (ACIHG 134.401).**"

**Amount in Dispute:** \$20,351.12

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary Dated April 12, 2006:** A completed Form DWC-060 was received from the carrier but it did not include a position statement.

**Response Submitted by:** City of Dallas, P.O. Box 162443, Austin, TX 78716

### **SUMMARY OF FINDINGS**

| Disputed Dates                      | Disputed Services           | Amount In Dispute | Amount Due |
|-------------------------------------|-----------------------------|-------------------|------------|
| July 10, 2005 through July 18, 2005 | Inpatient Hospital Services | \$20,351.12       | \$0.00     |

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of Benefits

- W1H – Workers compensation state fee schedule adjustment
- 97H – Payment is included in the allowance for another service/procedure.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration

*Dispute M4-06-4923 was originally decided on June 20, 2008 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 454-08-4141.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a February 16, 2009 SOAH order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed*

### **Issues**

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$44,984.59. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its original position statement asserts that "This claim has been reimbursed; however, it was not processed according to the Acute Care Hospital Fee Guidelines set forth by the TWCC ... This

methodology shall be used in place of and not in addition to the per diem based reimbursement system. Per TWCC guidelines, charges greater than \$40,000 are to be paid at 75% of billed charges. " In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor states "This claim has been reimbursed; however, it was not processed according to the Acute Care Hospital Fee Guidelines set forth by the TWCC. Please review this information and reprocess this claim. Explanation: Stop Loss is an independent methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services." The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
  - Review of the submitted documentation finds that the services provided were ICU/CCU; therefore the standard per diem amount of \$1,560.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was eight days. The ICU/CCU per diem rate of \$1,560.00 multiplied by the length of stay of eight days results in an allowable amount of \$12,480.00.
  - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed one unit of Albumin (Human) 5% 25GM at \$509.03/unit, for a total charge of \$509.03. The requestor did not submit documentation to support what the cost to the hospital was for Thrombin USP TOP. For that reason, reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$12,480.00. The respondent issued payment in the amount of \$13,387.33. Based upon the documentation submitted, no additional reimbursement can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
10/11/12  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**